

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195614	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Covenant Home		STREET ADDRESS, CITY, STATE, ZIP CODE 5919 Magazine Street New Orleans, LA 70115	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49753</p> <p>Based on observation, interviews, record reviews, facility document review, and facility policy review it was determined that the facility failed to protect a resident's right to be free from physical abuse for 1(Resident #3) of 3 residents reviewed for abuse.</p> <p>Findings included:</p> <p>Review of the facility's policy titled, Identification of Types of Abuse, dated April 2023, revealed, in part, 3. Physical abuse is defined as hitting, slapping, punching, kicking, etc.</p> <p>Review of Resident #3's medical record revealed, in part, Resident #3 was admitted to the facility on [DATE] with a diagnosis of sequelae of Poliomyelitis and hemiplegia.</p> <p>Review of Resident #3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/2024 revealed, in part, Resident #3 had a Brief Interview of Mental Status (BIMS) of 7, indicating severe cognitive impairment; and she was dependent upon staff for activities of daily living (ADLs) such as transfers, toileting, personal hygiene, bathing, and mobility.</p> <p>Review of Resident #3's Care Plan, with a review date of 11/06/2024 revealed, in part:</p> <p>Resident #3 requires assistance with transfers, will be monitored for maintenance of current level of mobility, requires two person total assistance and requires a mechanical lift (initiated 02/01/2024).</p> <p>Review of Resident #2's progress note dated 11/04/2024 at 10:06AM, by S6Licensed Practical Nurse (S6LPN) revealed, in part, a resident to resident altercation occurred, in which Resident #2 was witnessed in the dining room, approaching, punching, and placing her hands on Resident #3's face; as a result of this resident to resident altercation, Resident #2 caused a scratch to Resident #3's chin, with a small amount of bleeding. Further review revealed Resident#3 was aware of what occurred during the altercation.</p> <p>Observation on 11/04/2024 at 1:40PM, revealed Resident #3 had a small superficial linear scratch with redness on her chin.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/04/2024 at 1:40PM, Resident #3 indicated she was hit in the face by Resident #2.</p> <p>In an interview on 11/04/2024 at 1:50PM, S6LPN indicated Resident #3 was the victim in a resident-to-resident altercation with Resident #2. S6LPN further indicated the witnessed altercation between Resident #2 and Resident #3 occurred in the dining room, during the residents' activity group session on the morning of 11/04/2024. S6LPN also indicated Resident #3 was punched in the face and then grabbed and scratched in the face by Resident #2. S6LPN also indicated Resident #3 was very upset after the altercation because she was attacked and she could not defend herself due to her diagnosis of hemiplegia and Poliomyelitis. S6LPN further indicated Resident #3 had a superficial scratch to the chin as a result of the altercation.</p> <p>In a telephone interview on 11/07/2024 at 2:30PM, S4Resident Activity Director (S4RAD) indicated she witnessed the altercation, which involved Resident #2 and Resident #3 that occurred on a few minutes past 10:00AM on 11/04/2024, during an activity group in the facility's dining room. S4RAD further indicated she was assisting another resident to the table, when Resident #2 went up to, and hit Resident #3 in the face. S4RAD further indicated Resident #2 pressed both of her thumbs in Resident #3's eyes, and scratched Resident #3 on her chin, which resulted in a small amount of blood. S4RAD indicated she could not stop Resident #2 before she physically attacked Resident #3 because she was not within arm's reach; and Resident #3 was unable to defend herself, due to her paralysis related to her diagnosis of hemiplegia and Poliomyelitis. S4RAD further indicated the witnessed altercation when Resident #2 hit Resident #3 was considered physical abuse.</p> <p>In an interview on 11/07/2024 at 2:45PM, S10Resident Activity Aide indicated the witnessed altercation when Resident #2 hit Resident #3 was considered physical abuse.</p> <p>In an interview on 11/07/2024 at 2:50PM, S2Director of Nursing indicated the witnessed altercation when Resident #2 hit Resident #3 was considered physical abuse.</p> <p>In an interview on 11/07/2024 at 3:00PM, S1Adminstrator indicated the witnessed altercation when Resident #2 hit Resident #3 was considered physical abuse.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49753</p> <p>Based on interviews, record reviews, facility document reviews, and facility policy review, it was determined that the facility failed to ensure an alleged incident of resident to resident abuse was reported immediately, but no later than 24 hours, to Health Standards Section (HSS) for 1 (Resident #2) of 3 sampled residents for abuse.</p> <p>Findings Included:</p> <p>Review of the facility's policy titled, Identification of Types of Abuse, dated 04/2023 revealed, in part, 3. Physical abuse is defined as hitting, slapping, punching, kicking, etc.</p> <p>Review of the facility's Policy for Reporting Abuse, Neglect, or Misappropriation of Resident and Their Property, dated 04/2023 revealed, in part, 7. Reporting - In accordance with guidelines, alleged, and validated violations shall be reported to the governing state agency.</p> <p>Review of Resident #2's medical record revealed, in part, Resident #2 was admitted to the facility on [DATE] with a diagnosis of unspecified dementia with mood disturbance.</p> <p>Review of Resident #2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/27/2024 revealed, in part, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #2 had severe cognitive impairment.</p> <p>Review of Resident #2's Care Plan with a review date of 11/20/2024 revealed, in part:</p> <p>Problem: Behavior: Resident #2 had physically aggressive behavior. Episodes of physically aggressive behavior will not occur. Interventions: administer behavior medications as ordered by physician (initiated 04/21/2022); remove from public area when behavior is disruptive and unacceptable (initiated 04/21/2022); and notify physician if violence persists (initiated 04/21/2022).</p> <p>Review of Resident #2's progress note dated 11/04/2024 at 10:06AM, by S6Licensed Practical Nurse (S6LPN) revealed, in part, a resident to resident altercation occurred, in which Resident #2 was witnessed in the dining room, approaching, punching, and placing her hands on Resident #3's face; as a result of this resident to resident altercation, Resident #2 caused a scratch to Resident #3's chin, with a small amount of bleeding. Further review revealed Resident#3 was aware of what occurred during the altercation.</p> <p>In an interview on 11/04/2022 at 1:50PM, S6LPN indicated Resident #2 was involved in a resident-to-resident altercation with Resident #3, in which Resident #2 was the aggressor. S6LPN further indicated the witnessed altercation between Resident #2 and Resident #3 occurred in the dining room, during the residents' activity group session on the morning of 11/04/2024. S6LPN also indicated during the incident, Resident #2 placed herself in front of Resident #3 and hit Resident #3 in the face. S6LPN further indicated Resident #2 then proceeded to grab Resident #3's face and scratched Resident #3 on her chin.</p> <p>(continued on next page)</p>		

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